

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 21 Film 218 7 26 57 Reg. Dist. No. 07396

1. PLACE OF DEATH a. COUNTY <i>07413</i> <i>Baltimore</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burlock</i>	c. LENGTH OF STAY IN MD <i>Wife</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS <i>Burlock main</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>SUSAN</i>	Middle <i>Waples</i>	Last <i>Bell</i>	4. DATE OF DEATH Month Day Year <i>7 7 1957</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/30/1855</i>	9. AGE (In years (age birthday) yrs.) <i>70</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Benjamin Naples</i>	14. MOTHER'S MAIDEN NAME <i>Susan Coronell</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>CONFORMANT</i>	17. ADDRESS <i>Mrs Mary Bell, Burlock, Md.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
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PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>904.0</i>	
DUE TO (c) <i>Fracture neck r. femur.</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Slipped and fell in home</i>
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20c. TIME OF INJURY Hour o. m. p. m. <i>June 1957</i>	Month, Day, Year <i>20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Hurlock</i>	(County) <i>Dor.</i>	(State) <i>Md.</i>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
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ACTUAL SIGNATURE <i>John Mate Jr.</i>	DATE SIGNED <i>7/9/57</i>
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EXAMINER'S NAME (Type) <i>John Mate Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
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EXAMINER'S NAME (Type) <i>John Mate Jr.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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EXAMINER'S NAME (Type) <i>John Mate Jr.</i>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/9/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington</i>	22d. LOCATION (City, town, or county) <i>Hurlock, Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>J.B. McLaughlin</i>	ADDRESS <i>Burlock Rd.</i>	24a. REC'D BY REGISTRAR <i>7/9/57</i>	24b. REGISTRAR'S SIGNATURE <i>John Mate Jr.</i>
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BUREAU Y. 2

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07414

CERTIFICATE OF DEATH

Reg. Dist. No. 117397
116

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 10 1/2 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
3. NAME OF DECEASED (Type or print) MORRIS SHERMAN BOUNDS		d. STREET ADDRESS	
5. SEX MALE 6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9-23-1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AZARIAH BOUNDS		14. MOTHER'S MAIDEN NAME MARY WHITE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT EASTERN SHORE STATE HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) GENERALIZED ARTERIOSCLEROSIS 450.0 DUE TO		INTERVAL BETWEEN ONSET AND DEATH SEVERAL YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-29-1956 to 7-18-1957 that I last saw the deceased alive on 7-18-1957 , and that death occurred at 9:25 PM , from the causes and on the date stated above. ACTUAL SIGNATURE George E. Currier M.D. EASTERN SHORE STATE HOSPITAL PHYSICIAN'S NAME (Type) GEORGE E. CURRIER ADDRESS CAMBRIDGE, MARYLAND		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/21/57	
22c. NAME OF CEMETERY OR CREMATORIUM TARSONS CEMETERY		22d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson SALISBURY		ADDRESS	
24a. REC'D. BY REGISTRAR DATE JUL 22 1957		24b. REGISTRAR'S SIGNATURE John Moore, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLASSIFICATION OR DECODE

BUREAU V. A

JUL 22 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07492

CERTIFICATE OF DEATH

47398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS Travers Court Apts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First M.	Middle Bradley	4. DATE OF DEATH July 21, 1957	Month July	Day 21	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Sept. 4, 1971	9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Vienna Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zion		14. MOTHER'S MAIDEN NAME Elizabeth Ross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Renal Insufficiency						INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Nephrosclerosis				3 months	
		(c) DUE TO Coronary Heart Disease				10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 449 X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 136 Race St		20f. (City or town) (County) (State) Cambridge Md.	
21. I certify that I attended the deceased from 7/13/57 , 19, to 7/21/57 , 19, that I last saw the deceased alive on 7/21/57 , 19, and that death occurred at 7/21/57 , 19, M, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryland M.D.		ADDRESS (Street, city or town, state) 136 Race St					
PHYSICIAN'S NAME (Type) Lawrence Maryland		DATE SIGNED 136 Race St					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1957		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				24a. REC'D BY REGISTRAR DATE 7/24/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

WISCONSIN STATE GOVERNMENT OF MILWAUKEE - BUREAU OF
CENSUS OF THE STATE OF WISCONSIN

BUREAU
RECEIVED
JUL 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07399

07415

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge - Rural		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Irene Johnson		d. STREET ADDRESS Moores Ave.	
4. DATE OF DEATH July 3, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1906	
9. AGE (In years from birth to death) 50 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W. Meekins		14. MOTHER'S MAIDEN NAME Henrietta Pritchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-6952	
17. INFORMANT Grace Dunnock, Taylors Island, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Condition, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH July 1, 1957	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to July 2, 1957 that I last saw the deceased alive on July 2, 1957 , and that death occurred at None , from the causes and on the date stated above. ACTUAL SIGNATURE J. U. Thompson		ADDRESS (Street, city or town, state) Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Meekins Neck		22d. LOCATION (City, town, or county) (State) Meekins Neck, Dor. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hubert W. Clark		24a. REC'D BY REGISTRAR DATE 7/6/57	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE John Macey	

WISCONSIN STATE BOARD OF HEALTH-REGULATIONS
CERTIFICATE OF DEATH

BUREAU V. S.
JUL 8 1957
RECEIVED

THE STATE OF TEXAS - DEPARTMENT OF PUBLIC SAFETY
NOTIFICATION OF DEATH - CERTIFICATE

BUREAU Y. 8

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07493

CERTIFICATE OF DEATH

07401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY			
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If, outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle		
4. DATE OF DEATH		Month	Day		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years at birthday) yr.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. GIVEN NAME OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH INSTANT			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		SEVERAL YEARS			
(b)		ARTERIOSCLEROTIC HEART DISEASE			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat. while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		7/21/1957	1957	7/22/1957	1957
		that I last saw the deceased from the causes and on the date stated above ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		DATE SIGNED			
PHYSICIAN'S NAME (Type)		WALTER E. GUNSY JR. 105 CHURCH ST 29 JULY 59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	22e. SIGNATURE
Burial		7/27/59	Walter E. G. M. Market	East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
Walter E. G. M. Market		7/29/59	John Moore		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TYPEAU V. 8

CC 1 1057

TYPEAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07404

CERTIFICATE OF DEATH

Reg. Dist. No.

07402

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		b. COUNTY <i>Dor</i>	
c. LENGTH OF STAY IN b. <i>6 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elliot</i>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>Brady</i>	Last <i>Ewell</i>
4. DATE OF DEATH	Month <i>7</i>	Day <i>2</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OF FACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/27/1904</i>
9. AGE (In years and months) <i>53 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>John Ewell</i>	14. MOTHER'S MAIDEN NAME <i>Perle Dayton</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Glenn Brown</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>193X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. <i> </i> (c) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>Mon 6, 1957</i> , to <i>7-2 1957</i> , that I last saw the deceased alive on <i>7-2 1957</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Glenn Brown</i> M.D. <i>7-6-57</i> PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>7/5/57</i> 22c. NAME OF CEMETERY OR CREMATORI <i>Cambridge</i> 22d. LOCATION (City, town, or County) (State) 23. FUNERAL DIRECTOR'S SIGNATURE <i>John McCloskey</i> ADDRESS 24a. REC'D BY REGISTRAR DATE <i>7/8/57</i> 24b. REGISTRAR'S SIGNATURE <i>John McCloskey</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FBI BUREAU

100-10000

U. S. BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

117403.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
c. LENGTH OF STAY IN lb 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		b. COUNTY Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Elwood		d. STREET ADDRESS Near Elwood		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Henrietta	Middle Gleaves	Last Gleaves	4. DATE OF DEATH July	Month July 3 Day Year 1957
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1876	9. AGE (in years lost birthday) 81 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Warrington, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Mather Terry		14. MOTHER'S MAIDEN NAME Adaline Somervel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Betty Carrington, Hurlock, Md., R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		(Cerebral Sclerosis)		INTERVAL BETWEEN ONSET AND DEATH 21 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		Right Hem. plegia		21 day	
DUE TO (c)		Generalized Arteriosclerosis		20 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		21/4	1951 to 1957	that I last saw the deceased and that death occurred at 12:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Preston, Maryland	
ACTUAL SIGNATURE Harold B. Plummer, M.D.		DATE SIGNED 7/15/57			
PHYSICIAN'S NAME (Type)		Preston, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 5, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Johns Cemetery	22d. LOCATION (City, town, or county) (State) Near Preston, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR JUL 8 1957 DATE			
		24b. REGISTRAR'S SIGNATURE Alfredine			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Part 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IS A15 (4)
JSM 9/55

RECEIVED
MAY 8 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07418

CERTIFICATE OF DEATH

Reg. Dist. No.

07404

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg R.F.D.		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 45 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher Nursing Home		d. STREET ADDRESS same	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ellis Robinson Porter Grimes		First Ellis	Middle Robinson
4. DATE OF DEATH July 24, 1957		Month July	Day 24
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1900		9. AGE (in years lost birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY retired	
10c. BIRTHPLACE (State or foreign country) Newburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ellis R. Grimes		14. MOTHER'S MAIDEN NAME Harriett Wolf Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO no	
17. INFORMANT Mrs. E.R.P. Grimes		Address Hurlock, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0		Chronic lymphatic leukemia 4 mon	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		Atherosclerotic heart disease 10 years	
DUE TO (c)		Salivary gland infection, acute 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 441.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-28-1957 to 7-23-1957 , that I last saw the deceased alive on 7-23-1957 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hurlock, Md.		DATE SIGNED 7-23-1957	
ACTUAL SIGNATURE R. C. Kingsbury		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF July 27, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Washington Cem.		22d. LOCATION (City, town, or county) Hurlock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold Willensky		24a. ADDRESS Federalburg, Md.	
24b. REC'D BY REGISTRAR Aug 6 '57		24c. REGISTRAR'S SIGNATURE Paul Smith	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director.
 The certificate should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGULATED
BY BUREAU V. S.

UG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07405

Reg. Dist. No.

TO MEDI-CERT EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for filing or removal.

1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. S. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Rural - Cambridge				X/ Rural - Cambridge		R. F. D. #2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		R. F. D. #2							
3. NAME OF DECEASED (Type or print)		First Nehemiah	Middle	Last Hopkins	4. DATE OF DEATH	Month July	Day 1	Year 1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 24 HRS.	11. IF UNDER 1 YEAR	12. IF UNDER 24 HRS.	
Male Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 15, 1882	74 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Farmer		Farming		Dorchester Co., Md.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
William H. Hopkins		Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		220-28-2501		William Hopkins, Cambridge, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				Instant			
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED		7/2/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/1957		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Salem Cemetery		22d. LOCATION (City, town, or county) Salem, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Mace Jr.						24a. REC'D BY REGISTRAR DATE 7/3/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	
VS. A15ME(5) 5M 9/55									

BUREAU N.Y.

JUL 8 1901

REG'D'V'D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07406

CERTIFICATE OF DEATH

Reg. Dist. No.

07420

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek Md.		d. STREET ADDRESS Church Creek Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Creek Md.				d. STREET ADDRESS Church Creek Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Levin		First	Middle Lee	Last Jones	4. DATE OF DEATH July	Month July	Day 13	Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1874		9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Church Creek Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John W. Jones		14. MOTHER'S MAIDEN NAME Sarah Linthicum							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Fred Richardson		Address Church Creek Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (if any) DUE TO (b) DUE TO (c)		Arteriosclerotic Ht. Disease				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Arteriosclerosis, generalized				under			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. p.m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 136 RACE ST.		20f. (City or town) Cambridge		(County) Caroline	(State) MD
21. I certify that I attended the deceased from July 7, 1957 to July 13, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 136 RACE ST. M., from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R. Maryanov M.D.						ADDRESS (Street, city or town, state) 136 RACE ST.		DATE SIGNED 7/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Church		22d. LOCATION (City, town, or county) Church Creek		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR John Macep.		24b. REGISTRAR'S SIGNATURE			
				DATE 7/15/57					

REGELVETO

111-43-1257

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #2		d. STREET ADDRESS R.F.D. #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dora	First Whittington	Middle Lee	Last July 4, 1957
4. DATE OF DEATH July 4, 1957	Month July	Day 4	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1871
9. AGE (In years lost birthday) 86 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Whittington	14. MOTHER'S MAIDEN NAME Susan Anne Eaves	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-10-8630D	17. INFORMANT Rena Elliott, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 3 days		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1957, to July 4, 1957, that I last saw the deceased alive on July 1, 1957, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 227 Pine St-Camb., Md. DATE SIGNED 7-6-57			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/1957	22c. NAME OF CEMETERY OR CREMATORIUM Cordtown	22d. LOCATION (City, town, or county) (State) Cordtown, Dor. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Clark</i>	ADDRESS 1234 Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 7/10/57	24b. REGISTRAR'S SIGNATURE <i>John Tracey</i>

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07409

Reg. Dist. No.

07422

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Cure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek Md.		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fishing Creek Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek Md. x 2	
3. NAME OF DECEASED (Type or print) Hugh		First W.	Middle Lovette
4. DATE OF DEATH July 18 1957		Month July	Day 18
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 2, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govern Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Social Security Bd.	
11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Lovette		14. MOTHER'S MAIDEN NAME Marian Thorpe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ethel Lovette		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 42.3.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John McAe Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John McAe Jr.		DATE SIGNED 7/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM National Cemetery		22d. LOCATION (City, town, or county) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DATE 7/19/57	
ADDRESS Cambridge Md.		24b. REGISTRAR'S SIGNATURE John McAe Jr.	

BUREAU V.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08476

07423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Baby		First Boy	Middle Manokey
4. DATE OF DEATH July	Month 28	Day 19	Year 57
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1957
9. AGE (in years (at birthday) yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin Manokey		14. MOTHER'S MOTHER'S NAME Valerie Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mable Ross, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hemorrhage Tonic uterine contractions occurred before delivery	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While or work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/28, 1957, to 7/28, 1957, that I last saw the deceased alive on 7/28, 1957, and that death occurred at 11:30 M. from the causes and on the date stated above. ACTUAL SIGNATURE W.H. Hanks M.D.		ADDRESS (Street, city or town, state) 104 Locust DATE SIGNED 8/1/57 CITY BRIDGE Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/1957	22c. NAME OF CEMETERY OR CREMATORIUM Old Field
23. FUNERAL DIRECTOR'S SIGNATURE Herbert McGlasson		24a. ADDRESS Cambridge, Md.	24b. REC'D BY REGISTRAR DATE 8/9/57 John Moore Jr.

1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

074196

CERTIFICATE OF DEATH

Reg. Dist. No.

C7424

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 14 yrs. 28das		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		
3. NAME OF DECEASED (Type or print) Mary		First Elenora	Middle Martindale	
4. DATE OF DEATH July 16 1957	Month July	Day 16	Year 1957	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-6-88	
9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 69	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Martindale		14. MOTHER'S MAIDEN NAME Annie E. Tome		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn.		16. SOCIAL SECURITY NO. -		
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, generalized				
DUE TO (c) Senile Psychosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 11 1956 , to July 16 1957 , that I last saw the deceased alive on July 16 1957 , and that death occurred at 7:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. E. S. S. Hospital, Cambridge, Md. DATE SIGNED 7-16-57				
ACTUAL SIGNATURE <i>Edwin J. Ward</i>		PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-16-57		22b. DATE THEREOF July 19 1957	22c. NAME OF CEMETERY OR CREMATORIUM Hopewell Cemetery	22d. LOCATION (City, town, or county) Port Republic (State) MD
23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Miller</i>		ADDRESS Rising Sun, Md.	24a. REC'D BY REGISTRAR DATE 19 1957	24b. REGISTRAR'S SIGNATURE John Mace, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SCIENCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07411

7425

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge			c. LENGTH OF STAY IN 1b 3 mo.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital			d. STREET ADDRESS South Division St Ext.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First HARRY	Middle CLAY	Last McDANIEL	4. DATE OF DEATH July	Month July	Day 17	Year 19 57		
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/87	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (State or foreign country) Md. Somerset County				
13. FATHER'S NAME Peter McDaniel			14. MOTHER'S MAIDEN NAME Hester McGrath			12. CITIZEN OF WHAT COUNTRY U.S.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.			16. SOCIAL SECURITY NO. - - -			17. INFORMANT Mrs. Minnie McDaniel (Wife) S. Div. St. Ext. Eastern Shore State Hospital records -Sal. Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis										
450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 21. Psychosis with cerebral arteriosclerosis										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20d. INJURY OCCURRED p. m. 11:15 AM			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Fruitland	(County) Wicomico	(State) Md.
21. I certify that I attended the deceased from April 12, 1957 to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 11:15 AM , from the causes and on the date stated above										
ADDRESS (Street, city or town, state) Thomas T. Dredge M.D. E.S. State Hospital Cambridge, Md.										
DATE SIGNED 7-17-57										
ACTUAL SIGNATURE Thomas T. Dredge M.D. E.S. State Hospital Cambridge, Md.										
PHYSICIAN'S NAME (Type) Thomas J. Dredge										
Eastern Shore State Hospital—Cambridge, Md. 7/17/57										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) Fruitland, Maryland		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.					24a. REC'D BY REGISTRAR DATE 7/19/57					
					24b. REGISTRAR'S SIGNATURE J. Dredge 7/19/57					

BUREAU V. S

JUL 22 1957

REFUGEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07412

Reg. Dist. No.

7426

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY Dorchester	
Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
117 Race Street		117 Race St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Robert	Middle Franklin	Last Meekins
4. DATE OF DEATH	Month July	Day 19, 1957	Year 19
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 29, 1877
9. AGE (In years less birthday)	10. UNDER 24 HRS. Months	11. UNDER 24 HRS. Days	12. UNDER 24 HRS. Hours
789 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Insurance Agent		Cambridge	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
William H. Meekins	Martha Meekins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT	Address
	215-01-1544	George W. Meekins, 213 Belvedere Ave., Cambridge,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>			
440.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, BONE (Specify) Burial		22b. DATE THEREOF July 22, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Thomas</i>		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE 7/22/57		7/22/57 John Mace Jr.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.



BUREAU K-5

JUL 30 1957

REGELVÉD

John Wiley

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07413

07405 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate, Md.	
3. NAME OF DECEASED (Type or print) Planner		First Alfred	Middle Meredith
4. DATE OF DEATH July 1, 1957		Month July	Day 1
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 28, 1868		9. AGE (in years from birth) 89 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Waterman		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (State or foreign country) Wingate		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Amos A. Meredith		14. MOTHER'S MAIDEN NAME Mary 1st name unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Preston Meredith Toddville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 501.2		INTERVAL BETWEEN ONSET AND DEATH Myocardial Failure. Bilateral arteriosclerosis Severity	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Stranguled umbilical hernia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:00 A.M., from the causes and on the date stated above		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE W. H. Hanks		DATE SIGNED 104 Locust St. Cambridge, Md. 7/1/57	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Funeral Park, Cambridge, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Morris, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 7/5/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07406

CERTIFICATE OF DEATH

07414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crocheron Md.			
3. NAME OF DECEASED (Type or print) George		First W.	Middle Murphy		
4. DATE OF DEATH July	Month 21	Day 19	Year 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1900	9. AGE (In years from last birthday) 57	10. IF UNDER 1 YEAR OR UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Crocheron Md.	
13. FATHER'S NAME George D. Murphy		14. MOTHER'S MAIDEN NAME Amanda Todd		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-7103		17. INFORMANT Mrs. Emily Murphy Crocheron Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		Cerebral Hemorrhage 3 days		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge	(County) (State)
21. I certify that I attended the deceased from <u>7/21/57</u> , 19 <u>57</u> to <u>7/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>57</u> , and that death occurred at <u>7/24</u> , 19 <u>57</u> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D. DATE SIGNED <u>136 Race St.</u> <u>7/24/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE <u>7/25/57</u> 24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>		

HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filled with the registration number prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07415

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hurlock		c. LENGTH OF STAY IN 1b 3 weeks		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida b. COUNTY Dade	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deland		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert		First Albert Middle Oliver, Jr.		4. DATE OF DEATH Month 7 Day 3 Year 1957			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1957	9. AGE (In years last birthday) yrs. 3 Months 20 Days 0	10. IF UNDER 1 YEAR Hours 0 Min 0	11. IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert Oliver		14. MOTHER'S MAIDEN NAME Robert Lee Hester		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Robert Lee Hester, Hurlock, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sickle cell anemia 24.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. ACTUAL SIGNATURE Alfred R. Maryanov		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/24/57	
EXAMINER'S NAME (Type) Alfred R. Maryanov, M.D.		23. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORIAL Richards Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dornbissell, Easton, Md.		22d. LOCATION (City, town, or county) Easton, Md.		24a. REC'D BY REGISTRAR DATE JUL 17 '57		25. REGISTRAR'S SIGNATURE Alfred R. Maryanov	
VS. A1SME(5) 5M 9/55							

BUREAU Y. S.

JUL 17 1957

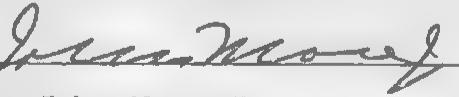
REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07416

Reg. Dist. No.

07407

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN lb 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland		d. STREET ADDRESS 33 High Street					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenburn Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Birdsell		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX	6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (in years at birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
female	white	WIDOWED	<input type="checkbox"/>	DIVORCED	Feb. 17, 1873	79 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Cambridge Md.			
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME William F. Drain					14. MOTHER'S MAIDEN NAME Louise C. Drain						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Earl W. Orem Cambridge Md.					
No		None		Earl W. Orem							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO 900.9 (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple contusions and lacerations.											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs in home.									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
6/28/57		Home		Cambridge		Dor.		Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) Dr. John Mace Jr.		7/24/57									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge		22d. LOCATION (City, town, or county) Cambridge		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge		24a. REC'D BY REGISTRAR DATE 7/24/57		24b. REGISTRAR'S SIGNATURE 					

BUREAU Y. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

87417.

07408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		b. COUNTY Dorchester Co.		
c. LENGTH OF STAY IN 16 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD #1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Cambridge RFD #1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Jennie	Middle Creighton	Last Reed	
4. DATE OF DEATH	Month July	Day 29,	Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1875	
9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	
13. FATHER'S NAME William Henry Creighton	14. MOTHER'S MAIDEN NAME Phoebe Lewis	15. CITIZEN OF WHAT COUNTRY USA		
16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Sidney Spedden	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO (b) DUE TO (c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH 7 days 10 days.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Locust	20f. (City or town) Cambridge	(County) (State) Md.
21. I certify that I attended the deceased from <u>7/22</u> , 1957, to <u>7/29</u> , 1957, that I last saw the deceased alive on <u>7/29</u> , 1957, and that death occurred at <u>1:55 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. H. Hanks</i>	ADDRESS (Street, city or town, state) 104 Locust, Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 31, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 9/16/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.	

BUREAU Y.

AUG 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07418

07499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address or institution)

MARYLAND

1b

1c

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE

ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED 8. DATE OF BIRTHWIDOWED DIVORCED 9. AGE (In years at time of death)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. PLACE (State or foreign country)

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS

Days

Hours

Min

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

351X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

1 day

Arterio sclerosis, generalized

10 yrs

19. WAS AUTOPSY PERFORMED?
YES NO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. MEDICAL CERTIFICATION

20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)20c. TIME OF INJURY
Month, Day, Year
Hour
o. m. 19
p. m.20d. INJURY OCCURRED
While
Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 7/6, 1957, to 7/7, 1957, that I last saw the deceased alive on 7/7, 1957, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

State

23. FUNERAL-DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RUPEAU V. S.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07419

Reg. Dist. No.

67428

1. PLACE OF DEATH a. COUNTY Dorchester Co.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Robbins Md.		c. LENGTH OF STAY IN 1b Life		b. COUNTY Dorchester Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Robbins Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Robbins Md.				d. STREET ADDRESS Robbins Md.					
3. NAME OF DECEASED (Type or print) James Jerome K. Shorter				First James	Middle Jerome	Last K.	4. DATE OF DEATH Month July		
5. SEX Male				6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 29, 1890	9. AGE (In years last birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trapping				10b. KIND OF BUSINESS OR INDUSTRY Fur		11. BIRTHPLACE (State or foreign country) Robbins Md.			
13. FATHER'S NAME Jerome K. Shorter				14. MOTHER'S MAIDEN NAME Mary C. Mills					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Fannie Slacum Robbins Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 420.1 10 mins.									
DUE TO Coronary sclerosis and									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized unknown									
DUE TO (c) --- --- ---									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
450.0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. --- ---		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) --- --- ---							
20c. TIME OF INJURY Hour a. m. p. m. ---		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- --- ---		20f. (City or town) --- --- ---	(County) --- --- ---	(State) --- --- ---
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
SIGNATURE Eldridge H. Wolff		DATE SIGNED 7-22-57							
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Sandy Island Cemetery		22d. LOCATION (City, town, or county) Robbins		(State) Kd.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge		ADDRESS d.		24a. REC'D BY REGISTRAR 7-22-57		24b. REGISTRAR'S SIGNATURE John A. Jr.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07420

07410

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Dorchester Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge Md.

c. LENGTH OF STAY IN TB

1 Day

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Cambridge Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE

Md.

b. COUNTY

Dorchester Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge RFD #3

d. STREET ADDRESS

Cambridge RFD #3

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or Print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Myra

Kirwan

Spedden

July

28

19 57

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Aug. 31, 1906

9. AGE (In years
last birthday)

50

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

12. IF UNDER 24 HRS

Hours

13. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None

14. FATHER'S NAME

T. James Kirwan

14. MOTHER'S MAIDEN NAME

Ella Clarage

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT

T. Medford Spedden Cambridge RFD #3

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH
12 hour

19. DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Generalized Arteriosclerosis

5 yrs.

(c)

Diabetes Mellitus

8 yrs.

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)

19. WAS AN AUTOPSY
PERFORMED?YES NO 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

22. TIME OF INJURY Month, Day, Year

Hour

o. p.m.

Month

Day

Year

23. INJURY OCCURRED

White

Not white

of work at work 24. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

25. (City or town)

(County)

(State)

26. ADDRESS (Street, city or town, state)

ADDRESS (Street, city or town, state)

27. DATE SIGNED

DATE SIGNED

28. I certify that I attended the deceased from

7/27, 1957 to

7/28, 1957

alive on

7/28

1957

and that death occurred at

5:45 P.M.

from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

29. SIGNATURE

Lawrence Maryanov

M.D.

136 Race St.

30. PHYSICIAN'S
NAME (Type)

Lawrence Maryanov

Cambridge, Md.

31. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

32. DATE THEREOF

July 30, 1957

33. NAME OF CEMETERY OR CREMATORIUM

Spedden-Seward's Cemetery

34. LOCATION (City, town, or county)

Cambridge RFD #3 Md.

(State)

35. FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

Cambridge Md.

36. REC'D BY REGISTRAR

J. A. MACE, JR.

37. REGISTRAR'S SIGNATURE

J. A. MACE, JR.

38. DATE

7/31/57

J. A. MACE, JR.

39. MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)	
Dorchester		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Cambridge		Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Cambridge-Md. Hospital		Bayly Road	
3. NAME OF DECEASED (Type or print)		First	Middle
Barbara		Anne	Stanley
4. DATE OF DEATH		Month	Day
July 23, 1957		Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Female		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years less birthday) yrs. Months Days Hours Min.	
Jan. 24, 1957		5 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		None	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cambridge, Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Levi Stanley		Laurena Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Laurena Stanley, Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia		INTERVAL BETWEEN ONSET AND DEATH 1 day	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Respiratory Infection		3 days	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 7/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/1957	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meekins Neck		22d. LOCATION (City, town, or county) (State) Meekins Neck, Dor. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Hollings</i>		24a. REC'D BY REGISTRAR DATE 7/26/57	
		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Pages 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07423

07412

Items 8,9 Film 217 7-10-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 60 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Linden Ave		d. STREET ADDRESS 6 Linden Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herman	First Herman	Middle B.	Last Taylor
4. DATE OF DEATH July 3 1957	Month July	Day 3	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1886
			9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Caroline Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George B. Taylor		14. MOTHER'S MAIDEN NAME Sarah Wrightson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Herman B. Taylor	Address 6 Linden Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) John Mace Jr. M.D.	DATE SIGNED 7/6/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 6, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge (State) d.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 7/6/57
			24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the rights to burial, cremation, or removal.

BUREAU V. S.

NY 9-1200

REGELVAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07424

Reg. Dist. No.

C7429

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 11 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 724 Parkway Circle			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS 724 Parkway Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sara		First	Middle	Last	4. DATE OF DEATH July 9 1957	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 22, 1911	9. AGE (In years last birthday) 60 45	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 17	Hours Min.	
8. OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland (Salisbury)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles E. Holloway		14. MOTHER'S MAIDEN NAME Flora Ella Lynch							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Bradley Taylor (Husband) 724 Parkway Circle-Sal. EASTERN SHORE STATE HOSPITAL RECORDS Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH 10 hrs.		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 322.0		Myocardial failure							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute alcoholism							?		
DUE TO (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 782.4		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John Mace, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 7-10-57		
EXAMINER'S NAME (Type) John Mace, Jr.		22b. DATE THEREOF July 12, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Persons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Persons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR 7/10/57		24b. REGISTRAR'S SIGNATURE <i>Lynn</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation.

BUREAU V. S.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07426

Reg. Dist. No.

7430

1. PLACE OF DEATH a. COUNTY <i>Dorchester Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Dorchester Co.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge Md.</i>		c. LENGTH OF STAY IN lb <i>10 Yrs.</i>		13. d. STREET ADDRESS <i>208 Willis St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>208 Willis St.</i>								
3. NAME OF DECEASED (Type or print) <i>R. Winfield Thomas</i>		First	Middle	Last	4. DATE OF DEATH <i>July 6, 1957</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11, 1877</i>	9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Neck Dist. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Wesley Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Not Known</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-12-1300</i>		17. INFORMANT <i>Mrs. Alverda Morgan Cambridge RFD # 2</i>		Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

instant

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. *19*

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

John Mace Jr. M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

John Mace Jr. M.D.

7/8/57

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 9, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Dorchester Mem. Park</i>	22d. LOCATION (City, town, or county) <i>Cambridge</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>LeCompte Funeral Service</i>	ADDRESS <i>Cambridge</i>	24a. REC'D BY REGISTRAR <i>DATE 7/8/57</i>	24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information, or removed.

VS. A15ME(5)
SM 9/55

REGISTRATION CERTIFICATE
MEDICAL EQUIPMENT CO. INC.

BUREAU Y. 8

JUL 10 1957

RECEIVED